HEALTH SERVICES IN BRITAIN

REFERENCE DIVISION
CENTRAL OFFICE OF INFORMATION
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CONTENTS

Introduction

The past century has been one of very great progress in the field of the medical and health services in Britain. The second half of the nineteenth century was marked by the development of environmental health services providing the basic conditions of healthy living. The early twentieth century saw the start of State aid for medical research, and, in the Medical Benefit of National Health Insurance in 1911, the beginnings of a State-aided general practitioner service outside the Poor Law.

The first inter-war decade is chiefly notable for the development of maternity and child welfare and of national schemes for the control of tuberculosis and venereal disease. In the second inter-war decade the Local Government Act of 1929 stimulated a rise in the standard of service offered by the municipal hospitals. The second world war served to emphasize the importance of a sound diet, and as a result the Welfare Foods Service for expectant mothers was introduced and the School Meals Service and industrial canteens were expanded. War also stimulated developments in industrial health services and in the rehabilitation of the disabled.

These improved services, together with advances in science and raised standards of living, are reflected in the vital statistics. The figures for England and Wales show a steady decline from the 1860s in mortality rates at all ages. Although tuberculosis is today the most serious menace among infectious diseases the death rate from it is only one-sixth of what it was in 1850, and there has been an equally remarkable decrease in deaths from most of the other dangerous diseases. By 1945, mortality of children under 15 from scarlet fever, whooping-cough, diphtheria and measles together had dropped to about one-thirtieth of the level prevailing a century earlier. Infant and maternal mortality have also declined very sharply since the mid-nineteenth century. The drop in infant mortality (under one year) has occurred mainly in the twentieth century—from 154 per 1,000 related live births in 1900 to 26·8 in 1953. Maternal mortality, still over 4 per 1,000 total births up to 1934, had fallen to 0·65 per 1,000 total births in 1953. Similar improvements are recorded in Scotland and Northern Ireland. Physique, moreover, has improved. The average child of 7 years old in the mid-1930s was already as tall and heavy as the average child of 8 years old thirty years earlier, and reports of school medical officers show that school-children in Britain today are healthier, taller, and generally of better physique than those of ten to twenty years ago.

This pamphlet describes first the public health services in England and Wales which seek to maintain a healthy environment and clean food, then the National Health Service which since 1948 has provided a comprehensive personal health service for everyone in Britain. Industrial health services and the school health service are the subjects of separate chapters since they

are organized as separate services. The chapters on health services in Scotland and in Northern Ireland deal only with those aspects, mostly administrative, of the services in these countries which differ from those in England and Wales. To complete the picture there are chapters on medical research and on professional training for medical and allied professions.

I

Public Health

Public measures to promote healthy living conditions in Britain preceded public provision for the care of the sick. Although at the Reformation in the sixteenth century the religious orders which had nursed the sick in the Middle Ages were swept away, and those sick persons who were destitute were subsequently provided for under the Poor Law, the main hospital and medical services in England and Wales remained almost entirely outside the sphere of public administration until the twentieth century.

The history of modern measures to promote public hygiene dates back just over a hundred years. Town councils had issued elementary sanitary regulations in the Middle Ages, and water supplies were first regulated in the sixteenth century and steps taken to check the spread of plague and other infectious diseases; but by the early part of the nineteenth century the rapid growth of towns as a result of the industrial revolution had created urgent sanitary problems calling for drastic new measures. Outbreaks of cholera and typhus at this time emphasized the total inadequacy of existing arrangements for public health, especially in towns.

The Public Health Act of 1848 is a landmark in public health history because it attempted to lay down a common minimum of sanitary services. It aimed at creating a comprehensive public health system to include a sound water supply, proper sewerage, improved drainage and cleansing, and street paving, and at bringing these services under unified control by local public health authorities supervised by a central Board. As a result of the Act, local authorities for the first time appointed Medical Officers of Health. The Act of 1848 pointed the way for the Public Health Act of 1875 upon which all subsequent legislation has been based. The Public Health Act of 1936 brought up to date and consolidated preceding acts, and constitutes the present basic public health code, for the implementation of which Local Health Authorities are mainly responsible. By this and other acts, local authorities have extensive powers for the making and administration of by-laws (laws of local application) relating to matters of public health.

The local authorities concerned in England and Wales are the councils of county and non-county boroughs, urban and rural district councils, and, to a limited extent, parish councils. The duties are carried out by the authority's Medical Officer of Health and his staff of sanitary inspectors and other officers.

WATER SUPPLY AND SEWERAGE

Water supply, sewerage and the prevention of river pollution in England and Wales are among the responsibilities of the Minister of Housing and

Local Government. The Water Act, 1945, gives powers for the control of resources, long-term planning of supplies, and the reorganization of areas of supply. The management of rivers, including the prevention of pollution, is in the hands of the River Boards set up under the River Boards Act 1948. (The rivers Thames and Lee have older-established Conservancy Boards.) Local authorities are required (by the Water Act 1945) to supply piped wholesome water to every part of their districts where there are houses or schools, to maintain wells, springs and water mains, and to ensure that supplies are free from pollution. The Rural Water Supplies and Sewerage Act 1944 empowers the Minister to make grants towards the cost of schemes of water supply and sewerage in rural areas. Piped water supplies now reach over 94 per cent of all households in Great Britain and 79 per cent of rural households.

It is the duty of every local authority to provide such public sewers as may be necessary for effectually draining its district and to make provision of effective sewage disposal works. The initial duty to construct drains and sewers falls upon the owner or developer of the property.

GOOD HOUSING

Housing is another important aspect of public health for which local authorities have wide responsibilities (mainly, now, under the Housing Act 1936, as amended by the Housing Act 1949, but also under the Public Health Act 1936 and the Housing Repairs and Rents Bill 1954). They are responsible to the Minister of Housing and Local Government for securing the repair, maintenance and sanitary condition of houses, the clearance and redevelopment of unhealthy and congested areas, the abatement of overcrowding, and the provision of housing accommodation to meet local needs[1]. Landlords are required by law to keep their house property in a fit state for human habitation, and if they allow it to fall below the prescribed standards the Medical Officer of Health may require them to carry out repairs, or, if the property cannot be rendered fit for habitation, it can be closed and scheduled for demolition.

CONTROL OF INFECTIOUS DISEASES

Local authorities are responsible to the Minister of Health for recording notifications of the prescribed infectious diseases, for the investigation of outbreaks of such diseases by the Medical Officer of Health, and for disinfection. They must also arrange for the control of personal infestation with vermin and for the provision of cleansing stations for this purpose.

HEALTH CONTROL AT SEAPORTS AND AIRPORTS

The Minister of Health also has the general responsibility for supervising the operation of the health control at seaports and airports, the primary object of which is to prevent the introduction of infectious disease into the

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[1] See *Housing in Britain*, COI Reference Pamphlet RF.P. 2797 (in preparation) for a fuller account of the housing powers and duties of local authorities.

country. It is operated at the principal seaports by Port Health Authorities specially constituted for the purpose, and at others by the riparian local authorities. At State airports the Minister is directly responsible for the control, but he has invariably delegated its operation to the local authority; at other airports the local authority is responsible.

Health control is applied in accordance with the Public Health (Ships) Regulations 1952, and the Public Health (Aircraft) Regulations 1952, which, *inter alia*, implement the International Sanitary Regulations adopted by the World Health Assembly in May 1951. At seaports the regulations are applied by the Port Medical Officer, assisted by Port Sanitary Inspectors, rodent officers and others; at airports the Airport Medical Officer is responsible for applying the Regulations, and where necessary he has lay assistants.

The control in normal circumstances is not onerous, and may consist of a rapid scrutiny of all arriving passengers, with a more detailed examination for special cases or the issue to passengers from certain areas of 'Warning Notices' (to be taken to a doctor if the passenger falls sick within 21 days of landing). In abnormal circumstances—for example, the arrival of a ship with infection on board—more detailed measures would be applied. Actual or suspected cases of infectious disease can be detained at any time, and contacts can be placed under surveillance.

Apart from this health control, certain categories of aliens arriving in the country may be subjected to detailed medical examination under the Aliens Order.

PURE FOOD

The purity, hygiene, composition and description of food are controlled by legislation now consolidated in the Food and Drugs Acts 1938 and 1950. The Acts and Regulations made under them are, broadly, executed and enforced by 'Food and Drugs authorities' (i.e. county councils, county borough councils and, generally, the larger borough and urban district councils) in relation to composition, adulteration and description, and by 'local authorities' (i.e. county borough, borough, urban district and rural district councils) in relation to purity and hygiene. The Ministries of Food and Health (and the Ministry of Agriculture and Fisheries where certain aspects of milk production and handling are concerned) are the central Departments responsible for advising and for making Regulations under the Acts. The Ministry of Agriculture and Fisheries is responsible under the Milk and Dairies Regulations 1949 for the registration of dairy farms and dairy farmers.

All premises where food for sale for human consumption is prepared, sold or stored are required to conform to certain hygienic standards. Authorized officers of Food and Drugs authorities and of local authorities are empowered under the Acts to take samples of any food for sale for human consumption, for analysis, or for bacteriological or other examination. Special Regulations are in force for certain foods such as milk, meat and ice-cream.

A Food and Drugs Amendment Bill which proposes powers wider and more detailed than those existing at present for Food and Drugs authorities, and local authorities, was introduced in November 1953.

OTHER PUBLIC HEALTH DUTIES

The public health functions of local authorities also include street cleansing and refuse disposal, the provision of burial grounds, the provision of baths and washhouses, disinfestation and rodent control, and the abatement of smoke and other nuisances, such as those arising from the processes of offensive trades.

The Shops Acts, of which the chief is the consolidating Act of 1912, empower local authorities to ensure that all shops in their areas have proper ventilation, temperature control, lighting, and sanitary and washing facilities, and that they observe the requirements of the Acts with regard to closing hours. The central authority concerned with these Acts is the Home Office.

Under the Public Health Acts, local authorities have power to regulate the provision of sanitary conveniences in places of work (as well as in houses) and to treat unclean or dangerously overcrowded or ill-ventilated places of work as nuisances, of which the abatement can be enforced. (For other industrial health measures see Chapter IV.)

II

The National Health Service

A century's progress in Britain's public health and medical services culminated on 5th July 1948 in the establishment of National Health Services throughout the United Kingdom. Similar services operate in England and Wales, in Scotland and in Northern Ireland, but with administrative differences (see Chapters V and VI).

The National Health Service Act 1946 aimed to 'promote the establishment in England and Wales of a comprehensive health service, designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis and treatment of illness'; and through its provisions the Minister of Health was made responsible to Parliament for seeing that health services of every kind, and of the highest possible quality, were available to everyone who needed them.

There was no intention that the introduction of the new health service should mean a complete break with the past. On the contrary, it was clearly understood from the beginning that all that was good in the existing services should be absorbed into the new scheme. What was aimed at was a strengthening and an expansion, so that benefits once available only to insured persons or those who could afford to pay for them, or as a form of charity, should come to be recognized as every citizen's right.

The essential freedoms have been safeguarded, for the public is free to use the Service, or any part of it, as it pleases. The patient is free to choose his doctor, and to change to another if he wishes to do so. The doctor is free from interference in his clinical judgment, and may make what criticism he wishes of medicine in general or of the Service. He may accept private patients while taking part in the Service.

SCOPE AND DEVELOPMENT

It was considered essential to regroup many of the health and medical services and to build up new administrative machinery to deal with them. Since the Minister of Health in his own person could not conceivably administer and manage all the services for which he was made responsible, provision had to be made for the delegation of his powers to appropriate boards and councils (see p. 15). The Service is constituted in three main parts: the hospital and specialist services; the general practitioner (including dental) services; and the local health authority services.

About 95 per cent of the fifty million population of the United Kingdom is using the Service. The great majority of specialists are taking some part, and between 90 and 95 per cent of general practitioners, over 90 per cent of

dentists, and almost all chemists are taking part. Over 20,000 general practitioners (principals and assistants) in England and Wales are in the Service, and over 2,500 general practitioners in Scotland. Only some 500 or 600 general practitioners remain outside the Service. Of about 10,000 practising dentists in England and Wales, 9,500 are in the Service, and 1,255 dentists in Scotland, practically all, are in the Scottish Service. Nearly 1,000 ophthalmic medical practitioners and over 6,000 opticians in England and Wales, and 80 ophthalmic medical practitioners and 850 opticians in Scotland are engaged in the Eye Services. Chemists in the Service number about 15,000 (almost all) in England and Wales, and 1,750 in Scotland. Over 3,000 hospitals have been brought within the Service.

In England and Wales the 2,688 hospitals in the Service had at the end of September 1953, 471,367 staffed beds, about 35,000 more than at the start of the Service, including several thousand beds specially set aside for mental illness. The nursing staff in these hospitals comprised 136,528 full-time and 27,370 part-time nurses, and 8,859 full-time and 1,176 part-time midwives. There are besides about 250 hospitals and homes remaining outside the Service for special reasons (most of these are run by religious orders), as well as private nursing homes, which must be registered as such.

In the first five and a half years over 1·6 million of all the main types of appliances were supplied through the Service in England and Wales, and 344,850 hearing aids. The special distribution service for hearing aids is being steadily developed.

In the general medical service the maximum permitted number of patients' names to be put on one principal's list is 3,500 (reduced from 4,000 in 1953), and the present average number is about 2,400. After four and a half years of the Service, the Medical Practices Committee for England and Wales reported an increasing number of doctors in general practice within the Service, and a well-established trend towards a more even distribution of general practitioners. In the same period the number of practitioners in 'under-doctored' areas increased by over 11 per cent, while there was a decrease of nearly 10 per cent in the number of doctors practising in areas where the proportion of doctors to patients was comparatively high. This trend results from the provisions of the scheme (see p. 20), but it results as a natural process from the voluntary choice of doctors and not from direction by any statutory body. No doctor is forced to remove from his existing practice, but he may be prevented from starting practice in a new area if it is already well served, and he will be encouraged to choose one of the areas where doctors are most needed.

The working of the Service in all its branches is continuously under review, and modifications and improvements are being made as their desirability emerges. Amending Acts were passed in 1949, 1951 and 1952 (see Appendix II).

Cost and Charges

About four-fifths of the cost of the National Health Service falls on the Exchequer. The balance is met by a transfer from the National Insurance

Fund, staff superannuation contributions, payments by persons using the Service, and local rates. Half the expenditure by local health authorities is refunded to them by the central Health Departments.

Since 1950 an attempt has been made to check the rising expenditure on the National Health Service and to keep the net total cost to the Exchequer for the Service in Great Britain from greatly exceeding £400 million[1]. This figure was exceeded in 1952 to cover the exceptional expenditure in that year on the retrospective payment of additional remuneration to general practitioners. In order to limit expenditure without reducing the services offered, it was found necessary to empower the Minister to introduce charges for certain items in the Service.

The National Health Service (Amendment) Act 1949 gave the Minister power (used in 1952) to introduce a charge for prescriptions (see p. 22). The National Health Service Act 1951 authorized the making of charges to meet part of the cost of dentures and spectacles supplied through the Service (see pp. 21–22). These charges operated from 21st May 1951. The National Health Service Act 1952 authorized the making of charges for medicine and certain appliances supplied to hospital out-patients, for dental treatment (excluding examination) provided under the General Dental Services, and for day nurseries run by Local Health Authorities. These charges came into force on 1st June 1952. Certain persons are exempted from paying the various charges, or are entitled to a refund, and any other person may apply to the National Assistance Board on grounds of hardship for help in meeting the charges. In addition to the introduction of charges, several administrative measures have been taken to secure economy in the Health Service without prejudice to the quality of service provided.

A clause in the 1949 Act empowered the Minister, if he so wished, to make regulations for the recovery of the cost of treatment under the National Health Service from any person normally resident overseas. Immigration authorities have been instructed to refuse admission to people who come to Britain only to use the Health Service. This does not mean that a visitor from overseas is no longer welcome to free treatment, as an act of hospitality, for illness or accident overtaking him during his stay.

The 1951 Act also empowered the responsible Ministers to make arrangements for the treatment in other countries of patients suffering from respiratory tuberculosis, and a number of patients have been sent to Switzerland under such arrangements.

Problems

The future development of the Service has still to take account of a number of problems, but none of them appears to be insoluble. There is, for example, the problem of securing maximum co-operation between the different branches of the Service (i.e. the local authority, practitioner, and

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[1] For tables of National Health Service expenditure see Appendix I.

hospital services), especially with regard to such subjects as maternity care and the prevention and treatment of tuberculosis, where an integrated service taking account of the whole field is of particular importance. The ideal of making the Service available to meet every medical need involves obvious dangers to economy. For example, the free transport provided for patients was at first too freely used, and steps had to be taken to limit this service to cases in which it was essential. The number and type of staff needed to administer a co-ordinated hospital system with efficiency and economy must necessarily be to some extent the subject of experiment, and the question of hospital staffing is kept under constant review.

ORGANIZATION IN ENGLAND AND WALES

The Minister of Health has direct responsibility for (*a*) the provision on a national basis of all hospital and specialist services; (*b*) the mental health functions previously in the hands of the Board of Control—except for the quasi-judicial functions designed to safeguard the liberty of the patient[1]; (*c*) the conduct of research work into any matters relating to the prevention, diagnosis and treatment of illness or mental defect; (*d*) a Public Health Laboratory Service; and (*e*) a Blood Transfusion Service. He has assumed indirect responsibility for the organization and maintenance of health centres, the establishment and maintenance of General Medical Services, and for the management of all other services.

The Minister discharges his responsibilities under the Act through Regional Hospital Boards, Boards of Governors of Teaching Hospitals, Executive Councils and Local Health Authorities.

Central Health Services Council

The Minister is advised in the discharge of his responsibilities by the Central Health Services Council, which reviews the general development of the Service and makes a special study of any subject to which, in its view, the Minister's attention should be called, and by a number of Standing

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[1] In 1913 the newly constituted Board of Control became the authority responsible for supervising the performance by the local authorities of their duties under the Lunacy Acts. At the same time the Board was charged with the general supervision of matters relating to mental defectives, who for the first time were accorded separate legal status. Under the National Health Service Act these supervisory functions were transferred in July 1947 to the Minister of Health, together with the powers of licensing, or other formal approval, by which the standards of accommodation for mentally ill or defective patients outside the National Health Service are still safeguarded. The Board of Control, however, as an independent body exercising quasi-judicial functions, continues to be responsible for matters affecting the liberty of the patient, that is, it still deals with admission, discharge and periodical review of patients under the Lunacy Act, the Mental Treatment Act and the Mental Deficiency Act. The Board's Commissioners and Inspectors continue to visit and inspect all institutions for mentally ill or mentally defective people, irrespective of whether such institutions are maintained as part of the National Health Service or not.

In October 1953 it was announced that a Royal Commission would be set up to inquire, as regards England and Wales, into the existing law and administrative machinery governing the certification and care, other than hospital care or treatment under the National Health Service Acts, of persons suffering from mental illness or defect. The Royal Commission held its first public meeting in May 1954.

Advisory Committees, which he has established on the recommendation of the Central Council[1]. These committees at present consist of:

The Medical Committee
The Dental Committee
The Pharmaceutical Committee
The Ophthalmic Committee
The Nursing Committee
The Maternity and Midwifery Committee
The Tuberculosis Committee
The Mental Health Committee, and
The Cancer and Radiotherapy Committee.

The Medical, Dental, Pharmaceutical and Ophthalmic Committees are professional in character, while the others include lay members and review the whole scope of the services in their particular field.

In addition to the Standing Advisory Committees, the Central Council sets up committees of its own as need arises: these have included one to study health centres and to suggest the lines along which these may most successfully be developed; one on the administration and organization of the hospital services; one on prescribing; one on co-operation between hospital, local authority and general practitioner services; and one on general practice. These committees include co-opted members from outside the Council, and such bodies as the British Medical Association (the doctors' professional association) are consulted.

Regional Hospital Boards

The 14 Regional Hospital Boards, which are in general charge of the hospital and specialist services, operate in areas determined as far as possible so as to secure that these services are conveniently associated with a university having a school of medicine. Each board has a membership of between 22 and 32 persons, including members appointed after consultation with hospital governing bodies, local authorities, doctors, dentists, nurses, industrialists, trade unionists and others. All appointments are honorary. The term of office is three years, one-third of the Board retiring annually and being eligible for reappointment.

Boards of Governors of Teaching Hospitals

Hospitals in the Service are under the management of the Regional Hospital Boards, with the exception of those designated as teaching hospitals, i.e. those recognized by the Minister of Health as providing, or able to provide in the future, facilities for undergraduate and post-graduate teaching. Teaching hospitals (of which there are 36 at present) are the centres of clinical teaching and technical experiment and innovation, and it is accepted

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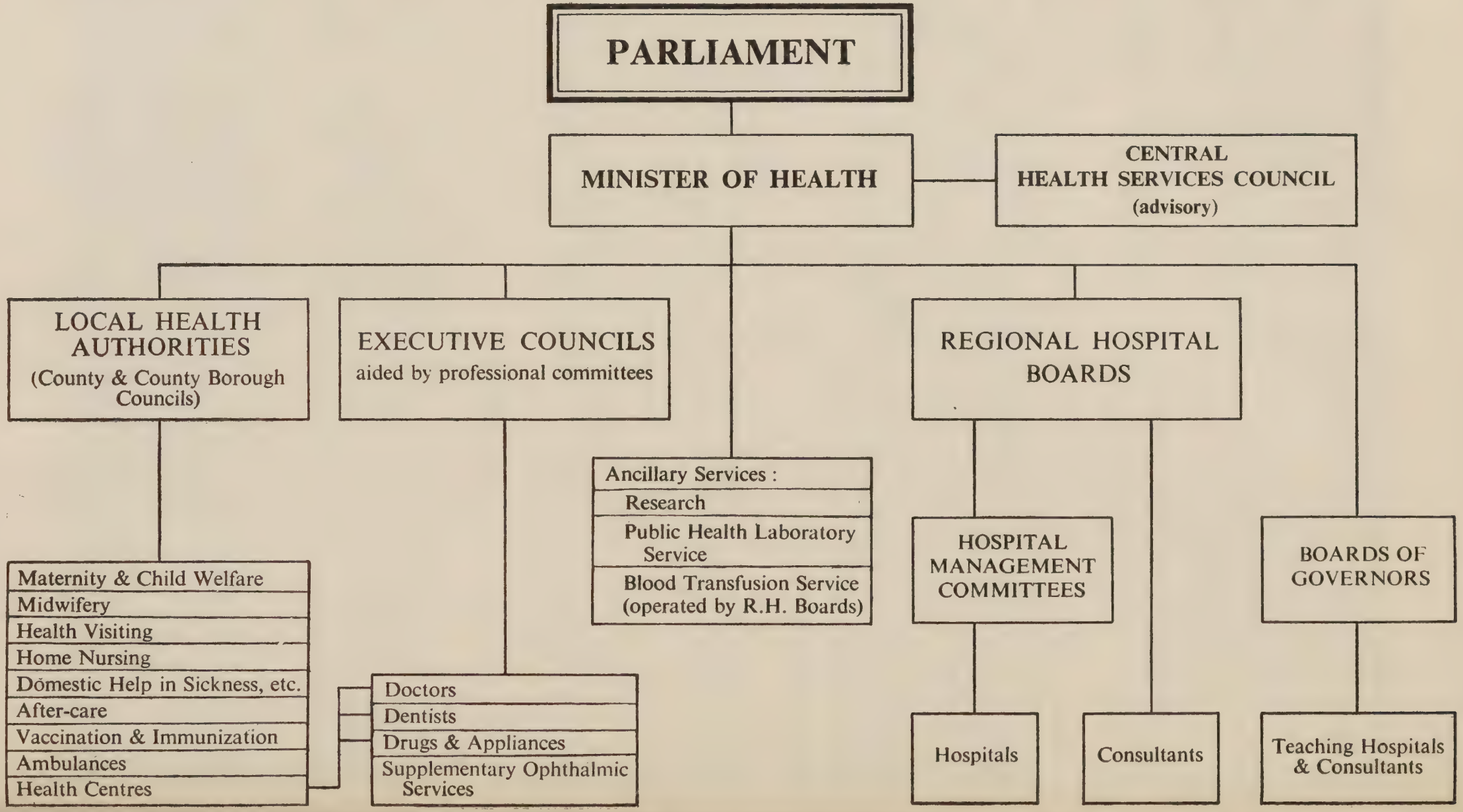
[1] The Central Health Services Council was constituted under the National Health Service Act 1946, and, with the exception of six *ex officio* members, the members are appointed by the Minister after consulting the relevant representative bodies. The six *ex officio* members are the presidents of the Royal College of Physicians of London, the Royal College of Surgeons of England, the Royal College of Obstetricians and Gynæcologists, and the General Medical Council, and the chairmen of the councils of the British Medical Association and of the Society of Medical Officers of Health. The rest of the membership is representative of medical and dental practitioners, registered nurses, certified midwives and registered pharmacists, and of persons with experience in hospital management, local government and mental health service. For published reports of the Council and Committees see p. 53.

ORGANIZATION OF THE NATIONAL HEALTH SERVICE IN ENGLAND AND WALES



that as much freedom of action must be accorded to their managements as is compatible with their position as public servants. For this reason, each teaching hospital has its own Board of Governors, which is solely responsible (under the Minister alone) for its organization and control.

Medical and dental schools in London continue under the control of their own governing bodies. Elsewhere they are controlled by the governing bodies of the universities of which they form part.

Hospital Management Committees

The detailed internal administrative work connected with individual non-teaching hospitals or groups of hospitals is carried out by 388 Hospital Management Committees, which are appointed by the Boards in consultation with the Local Health Authorities, the Executive Councils, and the senior doctors and dentists working in the hospitals. These committees are responsible for the day-to-day supply and maintenance of their hospitals, and for the appointment of all staff except the most senior officers. Although their powers are delegated from the Regional Boards, they have complete freedom of decision and enforcement; they are not required to refer back to the boards, except in matters of such moment as obviously to require that course.

Executive Councils

The 138 Executive Councils are responsible for the administration and general management of the Family Practitioner Services. Each has 25 members, 12 of whom have been appointed by the local doctors, dentists and pharmacists. Since the work of the Councils closely affects members of the medical, dental and pharmaceutical professions, and includes the publication of lists of doctors, dentists and others who are taking part in the public service in their respective areas, each Council is assisted in its duties by Area Committees representative of the various professions concerned.

Local Health Authorities

The 146 Local Health Authorities, which are the councils of counties and county boroughs (the Isles of Scilly are deemed a local health authority under the Act), are responsible for providing those services, e.g. maternity and child welfare, health visiting, vaccination and immunization, etc., which have been in operation under local government auspices for many years. They are also responsible for ambulances, home nursing and domestic help schemes, and all other services for the prevention of illness and care and after-care (including cases of mental illness and mental deficiency), and for the establishment and maintenance of health centres (see p. 25).

HOSPITAL AND SPECIALIST SERVICES

The hospital and specialist services provide all forms of hospital care and treatment, for both in-patients and out-patients, in every kind of hospital, in maternity homes, tuberculosis sanatoria, infectious disease units, institutions for the chronic sick, convalescent homes and rehabilitation centres.

They also provide specialist opinion and treatment, e.g. plastic surgery, cancer treatment, orthopædic and ear, nose and throat treatment, either in hospitals, institutions and clinics, or, where this is medically necessary, at the homes of the patients. A blood transfusion service and a pathological laboratory service are at the disposal of every hospital as part of the general services.

All these services are available to every member of the public without any insurance qualification whatsoever. As a general rule, they are obtained through the patient's family doctor, who makes all arrangements both for the specialist services and advice, and for hospital accommodation where this is necessary. The Service provides free treatment and free maintenance in hospital. Charges for medicine, dressings and appliances supplied to out-patients were introduced in June 1952. These charges include 1*s*. on each prescription form for drugs or dressings, charges of 5*s*. to 10*s*. each item for elastic hosiery, £1 each for surgical abdominal supports, £3 a pair for surgical footwear (and charges for repairs) and £2 10*s*. for a wig. Repayment or exemption is allowed to persons in receipt of National Assistance, to war pensioners in respect of treatment for their pensionable disabilities, to patients attending venereal disease clinics in respect of that treatment, and for children under sixteen (or over, if in full-time attendance at school).

The majority of patients are accommodated in general wards, but certain hospitals have private rooms or wings, which, if not required for patients needing privacy on medical grounds, may be made available to patients desiring it as an amenity. In such cases, the hospital makes a charge representing the additional cost over the cost of maintenance in a general ward, but the patient pays nothing towards the cost of treatment nor towards the normal cost of maintenance. Where hospitals have put a number of pay-beds at the disposal of part-time specialists (both physicians and surgeons) taking part in the Service, for the use of patients who have decided not to take advantage of the scheme, patients are charged for full hospital maintenance as well as for the specialist's fee. In most cases, a maximum limit is prescribed for the fees that may be charged by the specialist to patients occupying private pay-beds.

The hospital and specialist services also provide a certain amount of after-care and convalescence for hospital patients needing regular attention after recovery.

A number of new diagnostic ear clinics have been established in hospitals and hearing aids of the special 'Medresco' type, designed and made for the Service, are supplied to patients referred from the clinics at distribution centres manned by specially trained technicians. These aids are serviced and maintained without charge.

Particular attention is being paid to that part of the hospital and specialist services which provides care and treatment for what may be termed 'socially significant' diseases, e.g. tuberculosis (see also p. 26), venereal disease, and mental defectiveness (see also p. 27). Special regulations ensure confidential treatment for persons attending venereal disease treatment centres, in order

that voluntary attendance at clinics, which worked satisfactorily in the past, should be further encouraged and maintained. A Standing Mental Health Committee has been appointed by each Regional Hospital Board to look after all mental hospitals, mental deficiency institutions and mental specialist services within the region; and it has been made illegal to accommodate mentally ill persons in the local authority institutions, as was often the practice in the past.

Blood Transfusion

The National Blood Transfusion Service is administered by the Regional Hospital Boards under the National Health Service. Each of the 12 regions is centred on a university town, where an organization is maintained for collecting blood within the region. The blood is kept in the Regional Blood Bank, or issued to Area Blood Banks which are maintained at general hospitals in each county. Each of the principal hospitals holds a supply of blood sufficient not only for its own needs but also for the smaller hospitals, nursing homes and general practitioners in its district. The blood is provided free by voluntary donors recruited from the public.

Rehabilitation

Rehabilitation departments are established at the main hospital centres. The work is carried out under the guidance of the appropriate medical specialists by physiotherapists, remedial gymnasts, occupational therapists and social workers, working as a team. The aim is to prevent undue disability and to restore fitness after all forms of sickness and injury. Experience has shown that efficient medical rehabilitation reduces the stay in hospital, the incidence of permanent disability and the period of incapacity for full work. The departments work in close association with the Disablement Resettlement Service of the Ministry of Labour and National Service. Rehabilitation methods have been applied with advantage in the care of the chronic sick and have enabled many to be discharged from hospital and to resume an independent life in their own homes.

Medico-Social Work

An increasing number of hospitals have an almoner's department staffed by medico-social workers specially trained to apply the principles of social case work to the problems of the hospital patient. The almoner's main function is to co-operate with the medical staff in their treatment of the patient; to minimize, by social action, the personal anxieties, family difficulties and other problems which arise during illness, and to ensure that after-care and help with adjustment to normal life or continuing disability are available when necessary. Social work in connection with psychiatric clinics and mental hospitals is carried out by another specialized type of social worker, the psychiatric social worker (see p. 29).

Some local authorities have appointed medico-social workers for social work in connection with the health and welfare services (in addition to the health visitor).

PRACTITIONER SERVICES

The practitioner services consist of the Family Doctor Service, the Dental Service, the Eye Service, and the Pharmaceutical Service, all of which provide the patient with the individual medical attention that he needs.

Family Doctor Service

Through the Family Doctor Service, the professional attention of a family doctor is made available to everyone. Patients may choose the doctor they wish, provided only that he is enrolled in the Service and that he consents to attend them. They may also change their doctor with a minimum of formality. The doctor has a similar freedom to accept or refuse patients as he wishes. He cannot be forced to attend any person against his will, although he has, of course, a general obligation to provide emergency treatment where necessary, nor does his enrolment in the Service preclude him from attending paying patients who have not joined the Service, if he cares to do so.

Doctors already practising in an area before 5th July 1948 were entitled to join the public service in that area and to continue practice as before. Any doctor now wishing to take up public practice must first get the consent of the Medical Practices Committee, in case there are a sufficient number of doctors in the area already. It is one of the aims of the National Health Service to improve the distribution of doctors, so that everybody may have an equal chance of first-class medical attention; and it is therefore essential to apply some limit to the number of practitioners in any given area.

The doctor in the Family Doctor Service is free to treat his patients exactly as he treated them in the past. There are no regulations as to what drugs or treatment he may prescribe, although the Chief Medical Officer has asked doctors to consider before prescribing any proprietary preparations whether a standard drug or combination of standard drugs can be prescribed with equal effect, and there is provision for the investigation of improper or excessive prescribing. If a serious illness develops or diagnosis is difficult, he may call in a consultant and secure hospital treatment without reference to any outside authority.

At present the Family Doctor Service is almost always organized from the doctors' own surgeries, to which patients go for advice and treatment, unless the doctor visits them at home. A few doctors work from health centres (see p. 25).

A doctor in public service is remunerated by a capitation payment (at present 17*s.* a year) for each patient registered with him, with an addition of 10*s.* for every patient within the range 501 to 1,500 on his list.

This scheme gives an annual remuneration ranging from £425 for a list of 500 patients to £3,475 for a list of 3,500. Doctors in the Service may in addition receive mileage payments for visiting in rural areas, inducement payments, averaging about £250 a year, for practising in difficult or unpopular areas, and grants or fees for special services, such as the treatment of temporary residents and emergency patients, the administration of anæsthetics,

the training of assistants, maternity work, hospital duties, and dispensing their own prescriptions. An initial practice allowance may be paid in addition to doctors taking up practice in areas designated as in need of more doctors. The allowance is paid on a descending scale (£600, £450, £200) for the first three years in the practice concerned, and is subject to conditions which have been agreed with the representatives of the profession.

Dental Service

Through the Dental Service patients are provided with all forms of treatment necessary for the restoration of dental fitness, and all repairs and replacements not necessitated by carelessness. As in the Family Doctor Service, there is complete freedom of choice by patients of dentists and by dentists of patients; and dentists may take private as well as National Health Service patients if they wish. Patients are not required to register with dentists, and the ordinary practice of visiting by appointment is maintained.

All conservative dental treatment, e.g. fillings and root treatment, extractions for the relief of pain, extractions not requiring replacement by dentures, and ordinary denture repairs, may be given without reference to any outside authority; but extensive and prolonged treatment of the gums, gold fillings, inlays, crowns, special appliances and dental surgery may be given only with the authority of the Dental Estimates Board. Any patient wishing for treatment or appliances that are more expensive than is clinically necessary will be able to have them with the authority of the Dental Estimates Board if he is prepared to pay the extra cost.

In May 1951 charges were introduced for dentures, whereby the patient has to pay an amount corresponding to about half the cost to the Exchequer. In June 1952 a charge of £1, or the full cost of any treatment if less than £1, was introduced. No charge is made for the clinical examination of a patient's mouth at six-monthly intervals. Charges for dental treatment (other than the supply or relining of dentures or additions to them) are not made for anyone under 21 years of age, or to expectant mothers, or mothers who have had a child during the preceding 12 months.

Dentists providing treatment in their own surgeries are paid on a prescribed scale of fees according to the items of treatment they have carried out.

Supplementary Ophthalmic Services

The Supplementary Ophthalmic Services, which form part of the Eye Services available under the National Health Service, provide for the testing of sight and the supply of glasses only. Anyone found to be in need of treatment or the more unusual glasses, or to be suffering from an abnormal condition of the eyes, is referred to his doctor for introduction, if necessary, to the Hospital Eye Service.

Any ophthalmic medical practitioner or ophthalmic optician who has joined the Service may be consulted and lists of such practitioners and opticians can be seen at any Post Office or Executive Council Office. A person using these services for the first time must obtain from his doctor a recommendation that his sight needs testing.

No charge is made for the testing of sight, but in May 1951 a charge for spectacles was introduced. The charge is 10*s*. for each lens, plus the actual cost of the frames, i.e. a total charge varying between 24*s*. 8*d*. and 43*s*. for a pair of spectacles. An additional charge is made for certain special lenses supplied at the applicant's own request. There is a free range of glasses available for children.

Glasses may be repaired or replaced partly at the cost of the Service if the loss or damage is judged not to have been due to the applicant's carelessness.

Help towards the cost of new glasses or frames only can be obtained on grounds of hardship from the National Assistance Board, and in cases of repairs and replacements from the Executive Council.

Ophthalmic medical practitioners and ophthalmic opticians are paid a prescribed fee for testing sight. Payment to opticians or dispensing opticians for the supply of glasses includes a dispensing fee for professional services, together with the wholesale cost of the glasses, and some addition to cover the risk of breakages.

Pharmaceutical Service

Through the Pharmaceutical Service, everyone receiving treatment under the Family Doctor Service is entitled to drugs, medicines and certain appliances prescribed by his doctor as part of that treatment. Any special appliances not covered by this part of the Service may be supplied through the hospitals. Chemists in the Service are required to be open at all reasonable times so that patients may be sure of getting their medicines without undue delay. There is a charge of one shilling on each prescription form (which may contain one or more prescriptions) made up by the family doctor and presented to the chemist for dispensing. A charge of 5*s*. or 10*s*. per item is made for elastic hosiery. These charges are refunded to war pensioners who need the prescription for an accepted war disability, to National Assistance recipients, and to others for whom payment would cause hardship assessed according to National Assistance Board standards. Payment to chemists is comparable with that received for private dispensing.

LOCAL HEALTH AUTHORITY SERVICES

The services provided by the 146 major local authorities in England and Wales, working through Health Committees, consist of the maternity and child welfare services, including welfare centres, maternity care, dental care and day nurseries; the services for the prevention of illness, care and aftercare, including vaccination and immunization, health visiting, home nursing and domestic help; the ambulance services; and the provision, equipment and maintenance of health centres.

Some of these services were already highly developed before the National Health Service Act came into force; others did not exist or were narrowly limited in their scope.

Maternity and Child Welfare Services

The Maternity and Child Welfare Services provide ante-natal and post-natal care for mothers, and general, medical and remedial advice for them and for children under five years of age.

These services are not compulsory, but every effort is made to make them convenient and attractive to mothers, and they are widely used. Specially trained doctors, nurses and midwives are in attendance at the ante-natal and post-natal clinics held at maternity and child welfare centres, while health visitors, working from these centres, call at homes in the district to give advice and help to mothers and to encourage them to attend the welfare centre. One out of two expectant mothers in England and Wales either attends clinics or, in sparsely populated areas where the provision of a clinic would not be justified, receives ante-natal care through local authority arrangements with private practitioners.

More than three out of four babies born in England and Wales attend the welfare centres. The children are weighed and records are kept of their progress. They are examined by the doctors, and orthopædic, ophthalmic, and sunlight treatment is available at many of the centres for the children for whom this is prescribed. Special clinics for test feeding and remedial exercises may also be arranged. Local Health Authorities are required in particular to provide free dental care for these mothers and young children, and their priority dental services are being expanded as more dentists become available. Where possible, special toddlers' clinics are arranged for children between two and five years of age.

Education in mothercraft by talks, demonstrations and classes is a feature of the service.

Arrangements for Confinement

The expectant mother may arrange to have her baby in hospital or at home according to the advice given her by her doctor or midwife, or according to her own preference if sufficient hospital beds are available over and above those required for priority cases, i.e. where domiciliary confinement is inadvisable for medical or obstetric reasons or because of adverse home conditions. For a home confinement, every mother has available to her the services of either a general practitioner obstetrician or her own family doctor, if he is willing to undertake her maternity care, besides those of a trained midwife employed in the domiciliary service of the local health authority. The doctor carries out certain ante-natal and post-natal examinations, attends at the confinement if he thinks it necessary and gives any other medical care required. Routine supervision and advice is provided by the midwife who visits regularly before the confinement for the purpose of examination and to give the mother advice and help generally. In addition, the expectant mother may attend the ante-natal clinic for instruction in the preparation for motherhood and in some cases for interim ante-natal supervision. The midwife delivers the patient (unless the doctor considers it necessary to be present) and continues in attendance for the first 14 days

after birth. Midwives work in close touch with the welfare centres in the care of the mother both before and after the birth of the child.

When the midwife ceases to attend a mother, or the mother returns home after confinement in a hospital, the health visitor from the welfare centre begins her regular visits.

The Care of Premature Infants

In order to reduce neo-natal mortality, i.e. the death of babies during the first month of life, special equipment is provided on loan to mothers whose premature babies can be nursed in their own homes. This equipment includes draught-proof cots, warm and suitable clothing, hot-water bottles and special feeding equipment. In addition, arrangements have been made whereby premature babies are attended by midwives and health visitors with a special training and experience of their needs.

Day Nurseries

A great many day nurseries were established during the war so that young children of women doing war work could be properly looked after. Many of these nurseries were closed down when the war ended, but a certain number remained to cater for the special needs of children whose mothers still had to go out to work, or whose home conditions were unsatisfactory. There are at present about 700 nurseries with places for about 35,000 children of five years old and younger. The nurseries are staffed by specially trained nursery nurses and nursery assistants. Power is given under the National Health Service Act 1952 to Local Health Authorities to make charges for the use of day nurseries. Privately run or factory day nurseries have to be registered with the Local Health Authorities, who may refuse registration for unsatisfactory premises or management. People who look after children under five years old in their own homes for payment must also be registered, so that some check may be kept upon the conditions in which the child is living.

Special Services for Unmarried Mothers

All these services are available to unmarried mothers and their children equally with other mothers and children. In addition there are special forms of help for the unmarried mother. Moral welfare associations provide specially trained workers to help the mother in making plans for herself and her child, and some of them also provide hostels for ante-natal and post-natal care. Local authorities can make a contribution towards the cost of this work in their areas and many of them do so. Others prefer to make their own provision through the health department.

Vaccination and Immunization

Arrangements are made with doctors for a service providing free vaccination against smallpox, and immunization against diphtheria. Parents cannot be compelled to make use of this service but they are given every encouragement to do so; and the success of the diphtheria immunization campaign is a very hopeful sign. In 1953 there were only 24 deaths from diphtheria in

England and Wales as against 2,641 in 1941; in Scotland, only 2 deaths as against 517 in 1941.

Health Visitors

The health visitors—who are qualified nurses with special additional training—give advice to expectant and nursing mothers on breast-feeding and on all aspects of the care of the baby, and on the nurture and management of children up to five years of age. Visits are paid to almost all babies. The National Health Service Act widened the duties of health visitors to cover advice to households on the care of the sick and on measures to prevent the spread of infection, with the intention that she should become the local health authority's main family visitor.

Home Nursing

A Home Nursing Service is provided to attend people who require nursing in their own homes. Nurses working in this service are either employed directly by the Local Health Authority concerned or by a voluntary organization acting as the agent of the authority, for before the coming of the National Health Service home nursing was widely organized on a voluntary basis by District Nursing Associations.

Domestic Help

Local Health Authorities have the power to make arrangements for providing domestic help in households where it is needed owing to illness, confinement, or the presence of children, old people or mental defectives. This is not one of the free services and authorities are authorized to recover from those assisted such charges as the authorities consider reasonable having regard to the person's means. Nearly all authorities provide this service.

Ambulance Service

Free conveyance between home and hospital or clinic is provided where necessary, either directly by Local Health Authorities or by arrangement with voluntary organizations. The Hospital Car Service (organized by the St. John Ambulance Brigade, the British Red Cross Society, and the Women's Voluntary Services) provides transport in many areas for patients who do not require an ambulance; such patients are conveyed in private cars whose owners volunteer to give this service, and the authorities make a mileage payment to the volunteers to cover their expenses.

Health Centres

It is the responsibility of the Local Health Authorities to provide, equip and maintain health centres to afford facilities under one roof for all or some of the following services:

(*a*) the Practitioner Services, including (by arrangement with the Local Executive Council) the Family Doctor Service, the Dental Service and the Pharmaceutical Service;

(*b*) the Specialist Services (by arrangement with the Regional Hospital Board);

(*c*) the Local Health Authority clinic services and services for health education.

Health centres have been established in some places in existing premises and a few new centres have been built. Scarcity of resources has prevented the building of centres on a large scale and it is now generally felt that the extensive provision of health centres should wait on the experience to be gained from the use of a limited number of experimental centres, usually in areas of new housing. Those already built or planned vary widely in their size and scope, from a pair of council houses adapted for group practice to the large centre built for the London County Council, which serves as an ideal demonstration of the possibilities of health centres as they were envisaged in the earlier years of the Service.

The London centre, at Woodberry Down, Stoke Newington, North London, opened in October 1952, is designed to serve some 20,000 or so residents living within a radius of about one mile of the centre. It brings under one roof ante-natal, post-natal and child welfare clinics, a school treatment centre, child guidance and medical exercise units and other services provided by the London County Council as local authority, and general practitioner and dental services provided by the Executive Council. There is accommodation for six doctors, two dentists, an eye specialist and ancillary staff, including dental technicians, nurses and receptionists, and an X-ray room and laboratory. A day nursery is included on the site.

The Prevention of Illness: Care and After-Care

Measures for the prevention of tuberculosis, e.g. the tracing of sources of infection, the prevention of its spread, and the removal of the cause of infection, are the responsibility of all the Local Health Authorities. Facilities for diagnosis and treatment are the responsibility of the hospital service and are provided through sanatoria and chest clinics. The chest physicians staffing these clinics are often employed jointly by the Regional Hospital Boards (or Boards of Governors) and Local Health Authorities to ensure that diagnosis and treatment are properly co-ordinated with prevention and after-care. Among the duties of these officers are those of making recommendations for residential treatment, visiting of homes of patients, and examining and advising 'contacts'. They are assisted in this work by tuberculosis health visitors and nurses. Most local authorities have statutory or voluntary tuberculosis care committees.

Mass miniature radiography was introduced in 1943 as a means of early diagnosis of tuberculosis. By the end of 1953 about 12½ million examinations had been made in England and Wales, and about 70 units were operating under the Regional Hospital Boards, in close co-operation with local authorities.

Care and after-care of patients is supplemented by general advice and assistance given to households in which the patients live. This includes supplying beds and bedding to enable the patient to sleep alone, providing nursing requisites, helping the family to find better housing accommodation, making arrangements for boarding-out the children of infected parents, helping to find extra food and clothing, and other similar matters.

Local Health Authorities send suitable patients to the village settlements for tuberculous persons run by voluntary bodies, and training for employment is carried out in conjunction with the training and resettlement schemes of the Ministry of Labour and National Service.

Care and after-care arrangements are made by some Local Health Authorities for other types of illness, including mental illness or mental defectiveness. Local authorities also provide or aid the provision of welfare services for handicapped persons under the terms of the National Assistance Act 1948.

A charge may be made for some of these services, if the person or persons wishing to make use of them can reasonably be expected to contribute towards their cost.

MENTAL CARE

The National Health Service Act 1946 brought mental and physical health together for the first time in one comprehensive service. The Minister of Health, as central authority in England and Wales for mental health, is now responsible for providing:

(*a*) hospital and institutional accommodation and all services, including nursing, for mentally ill or mentally defective persons, free of charge (subject to payment only for those received as private patients). (Institutions carried on for private profit—i.e. houses licensed under the Lunacy Act 1890 and the majority of approved homes for defectives under the Mental Deficiency Act 1913—were not transferred under the Act);

(*b*) services of specialists (free of charge) for mentally ill or mentally defective people.

Duties of Local Health Authorities

The 1946 Act required each Local Health Authority to establish a Statutory Health Committee, and the Minister recommended that it should appoint a mental health sub-committee to which would be assigned the responsibility for the provision and control of the mental health services for the area, whether under the National Health Service Act or the Lunacy and Mental Treatment or Mental Deficiency Acts.

The Local Health Authorities are now responsible for the community care of mental defectives and for the initial care and, if necessary, conveyance to hospital of patients suffering from mental illness, and also for after-care so far as this is not provided by the hospital services.

The officers mainly employed by the Local Health Authorities to carry out these duties are specialist social workers who work under the direction of the Medical Officer of Health. Some authorities have an Assistant Medical Officer with special duties in mental health. As regards mental defectives, the social workers are chiefly concerned with their ascertainment and supervision. The duties relating to mental illness are often combined with this work.

The majority of mental defectives are brought to the notice of the Local Health Authority through the schools, but others are referred from such sources as the courts, probation officers, infant welfare clinics, hospitals, the family doctor, parents or friends. On being reported to the Local Health Authority, the individual, whether child or adult, is first examined by a Medical Officer of the Local Health Authority (and in cases of doubt referred for specialist's opinion), and if the patient is found to be defective, the social worker then visits his home and makes contact with him and his parents or relatives. With the help of the social worker's report, the Medical Officer and the Mental Health Committee determine whether the defective is 'subject to be dealt with' under the Mental Deficiency Acts and, if so, what form of care is needed: whether it is to be supervision, guardianship or hospital care.

Mentally defective patients in institutions and under statutory care in the community at the end of the year 1953 numbered 119,197. Of these, 50 per cent were in institutional care, 3 per cent under guardianship or notified, and 47 per cent were under statutory supervision. In addition, 16,228 defectives were under voluntary supervision; 96 per cent of defectives in institutional care were in institutions or homes in the National Health Service.

Institutional and Community Care

The defective under supervision remains in his own home and receives periodic visits from the social worker, who gives such advice and help as will enable him to live a stable life in ordinary family surroundings. Alternatively, if he is fit to live in the community but closer control is needed, a judicial Order may be obtained placing him under the guardianship either of a parent or, more often, of a foster parent. The effect of the Order is to give the guardian the control a parent would have over a child of 14 and to require the guardian to undertake corresponding responsibilities. The Local Health Authority is responsible for seeing that the defective under guardianship is properly maintained. A defective may also be placed under the guardianship of an officer employed by a Local Health Authority and allowed to reside elsewhere; this enables suitable defectives capable of employment to be placed in carefully selected lodgings.

Training and occupation should be provided for the defectives living in the community in occupation centres, where most of those who attend are children. There are also recreational and industrial classes for mentally defective adults. The number of such classes is growing, but in rural and thinly populated areas the establishing of a centre is often impracticable and some Local Health Authorities are developing Home Teaching Schemes. Under these the teacher visits the home of the defective. Instruction given is chiefly in handicrafts, but valuable advice is given to parents. In a few areas, defectives who cannot go to a centre are gathered at the home of one of them or other suitable place where the home teacher can visit more often.

Many of the defectives sent to institutions become suitable, after a period of training, for return on licence to their own homes, or possibly those of high grades may be placed in residential employment. They continue under supervision, either by the social worker attached to the institution, if this is

practicable, or by the local authority's worker, unless and until they are discharged. They may then have the friendly help of the Local Health Authority and a form of after-care.

Care and after-care for the mentally ill or neurotic is also a Local Health Authority service (shared in practice with the hospitals) which is new but growing. The function of the social workers, working with the hospitals and the family doctor, is to reassure the patient and see that he obtains the form of help most suited to his needs, including medical and hospital care. In a few cases special clubs, often associated with a hospital, have been set up for psychiatric cases. In hospital a variety of treatments—physical, psychological, electrical, occupational, etc.—is available. The psychiatrists are assisted by social workers with specialist training called psychiatric social workers. These workers report on the social history and development of the illness and maintain close contact with patients and relatives throughout the hospital period, and continue to support the patient through the process of readjustment after discharge from hospital (unless he is, instead, visited by a social worker employed by the Local Health Authority). The demand for trained social workers in the mental health services at present far exceeds the supply.

At the end of 1952 there were in England and Wales 156,483 hospital beds for mental disorder and 54,794 for mental defectives, compared with 296,091 beds for all other types of illness.

The total number of persons under care for mental disorder was 151,378. Of this total 97·7 per cent were being cared for under the National Health Service.

A growing appreciation by the public in recent years of the value of early treatment and the possibility of admission to hospitals on a voluntary basis have led to greatly increased rates of admission to, and discharge from, mental hospitals.

In 1953, 69·8 per cent of patients admitted direct to mental hospitals were admitted voluntarily, and at the end of the year 23 per cent of all patients were voluntary patients. Calculated on direct admissions, the percentage discharged during 1953 as recovered or relieved was 69·3, while for recoveries alone the percentage was 23·7.

VOLUNTARY AID

A number of voluntary organizations provide extensive welfare services of various kinds for all manner of sick and handicapped persons in co-operation with, or supplementary to, the provision made by central and local authorities. Many convalescent homes and homes for the infirm and others specially handicapped have been provided by voluntary effort. Some of these are now absorbed in the National Health Service, others receive some aid from public funds. In many areas invalid children and others needing care in their own homes are visited and helped by voluntary organizations. Special organizations also serve the welfare of the blind, the deaf and other special classes. Though the need for material aid from private sources

becomes less as public provision extends, many special forms of help to meet individual needs that would not otherwise be met are given by voluntary agencies. Their most valuable service is probably to provide personal service and the continued personal interest that can contribute so much to the welfare of the sick and infirm. These voluntary agencies usually depend largely on the work, part-time or full-time, of unpaid volunteers.

III

The School Health Service

The School Health Service is in no way intended as a substitute for the National Health Service; and parents of schoolchildren are as free as any other citizens to avail themselves, on behalf of their children, of all that the latter has to offer. At the same time the State recognizes (and has recognized for nearly fifty years) that special medical care, both preventive and curative, is essential to the welfare of growing children, and that a School Health Service is the best means of providing it. Therefore, although the School Health Service has been closely co-ordinated with the National Health Service, it continues as a separate entity organized by the Local Education Authorities and designed to develop and maintain the physical and mental well-being of children who are being educated at publicly maintained schools.

MEDICAL INSPECTION AND TREATMENT

Through the School Health Service, every child attending a publicly maintained school undergoes a number of routine medical and dental inspections during his school career. Medical and dental treatment at school clinics is free. These clinics deal with minor ailments and, by arrangement with the National Health Service, provide consultative and specialist services, closely linked with the hospitals, for diseases of the ear, nose and throat, defective hearing, defective vision, and many other conditions.

It is also through the School Health Service that Local Education Authorities discover and examine children who suffer from disability of body or mind, for example from blindness, deafness, crippling, serious debility, backwardness or maladjustment, etc. It is the duty of these authorities to provide for such children the necessary special educational treatment, either in special schools or in other ways. The Special School system is being greatly extended (see *Education in Britain*, COI Reference Pamphlet RF.P. 2285).

CHILD GUIDANCE

Child guidance centres or clinics for the treatment of maladjusted children are provided by most local education authorities and also by many large hospitals and a few voluntary organizations. There are about 250 centres or clinics in England and Wales, though not all are full-time, and the service is being extended as rapidly as circumstances permit. In England and Wales those provided by local education authorities fall within the general responsibility of the Minister of Education, while those at hospitals or provided in other premises by Regional Hospital Boards form part of the National

Health Service under the Minister of Health. Child guidance centres and clinics are normally staffed by teams consisting of an educational psychologist, psychiatric social workers and a psychiatrist, with a school medical officer to conduct physical examinations. Sometimes there is a pædiatrician available for consultation, and the psychiatrist may be assisted by a non-medical child psychotherapist. The whole team works under the clinical direction of the psychiatrist. Many difficulties arising in school are educational in origin; these can be investigated by the educational psychologist and dealt with by her with the aid of the teachers in the child's school. Other difficulties appearing at home or in school may be investigated initially by the psychologist, either at the child guidance clinic or in the school, but she will need to consult other members of the team about them. The special function of the psychiatric social worker is to provide a report on the home, and after diagnosis of the child's trouble has been made, to take part in treatment by helping the parents to a better understanding of themselves in relation to their children. The function of the psychiatrist is to complete the diagnosis in cases of emotional disturbance and to recognize mental illness where it occurs; and then to advise on, and possibly himself (or herself) give, the appropriate treatment.

SCHOOL MEALS AND MILK

Milk (one-third of a pint a day) is given free to all children in school who wish to have it, and the School Meals Service provides a daily dinner at a subsidized price (remitted where there is need) to nearly half the pupils in schools maintained by Local Education Authorities. The school dinner is planned on a high nutritional standard so as to be the child's main meal of the day. The School Meals Service may also supply other meals, e.g. breakfasts, teas, etc., as required at a charge not less than the cost of the food.

IV

Industrial Health

Industrial health services are essentially preventive and include first-aid treatment for cases of accident or sickness. The present industrial health services have grown from two principal sources: the State and the employer. The State has appointed Inspectors of Factories, including Medical Inspectors to advise on and enforce the increasing volume of enactments concerned with the health of the workers. Employers have a general responsibility not to endanger the life and health of their employees and many have made arrangements, including the engagement of doctors and nurses, both to help them to comply with the statutory requirements and also in a spirit of enlightened management. The present position is therefore that protective legislation in mines, factories and industrial work-places generally is detailed and comprehensive and its enforcement strict, while a number of employers go well beyond the statutory requirements in providing for the health of the workers.

MINES AND QUARRIES

For mines and quarries, provision is made for dealing with such matters as ventilation, dust suppression, rescue work, first-aid, and the initial medical examination of certain new entrants by official doctors. There are many detailed requirements for the safe conduct of operations. The employment of women and children underground has been forbidden since 1842. These requirements are laid down in the Mines and Quarries Acts and Regulations and Orders, etc., made thereunder, which the Government proposes to revise, consolidate and extend. The Ministry of Fuel and Power is generally responsible for the administration of these enactments, while the Mines and Quarries Inspectorate, which is part of that Ministry, is directly responsible for their enforcement throughout Great Britain.

Since the nationalization of the coal-mining industry in 1946, the National Coal Board has extended the scope of its medical service, which at present consists of a chief medical officer, 9 divisional medical officers and 56 medical officers, who concentrate upon the medical needs of the workmen at individual mines. At 178 of the larger collieries, medical centres have been provided, comprising at least a treatment room, a doctor's/nurse's room, a waiting-room and storage space, with modern equipment, and mostly staffed by a state registered nurse under the supervision of a doctor. Centres are also being constructed, reconstructed and planned at 215 collieries. A first-aid room is normally provided at collieries where a medical centre is not available.

THE FACTORIES ACTS

Most other industrial premises in Great Britain come under the Factories Acts 1937 and 1948, which are administered by the Ministry of Labour and

National Service and enforced by the Factory Inspectorate which is part of that ministry[1].

A Factory Inspectorate appointed and paid by the central government was first created by the Factories Act 1833. The number of Factory Inspectors and Advisers has risen from 4 Inspectors and 14 Sub-inspectors during the first ten years to about 350 (all ranks and both sexes) at the present time. The number of premises subject to inspection has risen in the same time from just over 4,000 to about a quarter of a million. The present Acts lay down general requirements with regard to safety, such as the fencing and proper maintenance of machinery, lifting appliances, steam boilers and other pressure vessels; sound construction and proper maintenance of floors, passages and stairs and safe means of access to working-places; and the prevention of escape of dangerous fumes and dust into the workroom. They also prescribe general standards to safeguard health and welfare, e.g. with regard to cleanliness, the provision of sanitary accommodation, cubic space per worker, temperature, ventilation, lighting, washing facilities, accommodation for outdoor clothing, drinking-water, provision of seats, and arrangements for first-aid.

Any person intending to use premises as a factory has to notify the Inspector of Factories of his intention not less than one month before he begins to occupy them. All young persons under 18 years of age must be medically examined for fitness for employment by doctors appointed by the Chief Inspector of Factories on entry to employment in factories, at docks, or at building operations, and must be re-examined annually. The hours which may be worked by women and young persons between the ages of 16 and 18 are limited to 48 in a week and 9 in a day, although some overtime is allowed (up to six hours a week for not more than 100 hours a year). Young persons under 16 are limited to 44 hours of work a week. Adequate intervals for meals must be arranged for women and young persons and the employment of women and young persons by night is, in general, prohibited. No one under 15 years old may be employed on industrial premises.

These general requirements for safety, health and welfare may be supplemented or modified by regulations dealing with special risks or conditions in particular industries, processes, establishments or machines.

MEDICAL SERVICES

The medical services provided either on this statutory basis or voluntarily may be classified under four heads: the medical factory inspectorate, appointed factory doctors, industrial medical officers, and industrial nurses.

The Medical Factory Inspectorate

The Medical Factory Inspectorate at present consists of 13 medical inspectors who form part of the Factory Department of the Ministry of Labour and National Service. Their duties include special investigations in connection with questions of industrial hygiene, the investigation of industrial

[1] For the duties of local health authorities with regard to places of work see p. 10.

conditions in so far as they affect the health of the workers, and inquiries into cases of industrial disease and processes directly dangerous to health. The medical inspectorate supervises the work of the appointed factory doctors.

Appointed Factory Doctors

Appointed Factory Doctors are appointed by the Chief Inspector of Factories to carry out the statutory medical examinations required in factories; they are also required to investigate cases of notifiable industrial disease and of certain accidents. Each factory doctor usually serves a particular district and the whole of Great Britain is covered by the service. Most of the doctors are in practice in the National Health Service, and the proportion of their time which they spend on industrial work varies considerably.

Industrial Medical Officers

In addition to the above two services which cover all factories, there are at some factories services provided voluntarily by employers. These are the responsibility of industrial medical officers. The duties of each medical officer vary from factory to factory but the following examples indicate the range of their work:

General advisory services on industrial hygiene, including advice on the design and layout of processes and buildings, on dangerous hazards, on the study of sickness, absenteeism, and questions of personnel and group morale, and on the cause and prevention of industrial disease.

Examination of individual workers, e.g. of workers who are exposed to occupational hazards or who have returned to work after illness or injury, with a view to advising managements as to their conditions of employment.

Supervision of first-aid and nursing services and of follow-up services after cases of illness.

Promotion of the education of workpeople in matters of general and personal hygiene.

A committee on industrial health services which reported in 1951 found that there were at that time about 230 doctors engaged whole-time on factory work and that, including whole-time doctors, there were 1,287 doctors taking part in factory medical services, in addition to 1,789 appointed factory doctors[1].

Industrial Nurses

The Committee on Industrial Health Services estimated that in 1951 there were about 2,600 state-registered nurses and 1,400 other nursing staff employed in factories.

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[1] Report of Committee on the Industrial Health Services, Cmd. 8170, HMSO 1951, 1*s.* 3*d.*

RESEARCH AND ADVISORY BODIES

A number of official and voluntary bodies help to supply the research, advice and assistance necessary for developing higher standards of industrial health and welfare. These bodies include, besides the Factory and the Mines and Quarries Inspectorates, such Government agencies as the Medical Research Council, the Department of Scientific and Industrial Research (including the National Physical Laboratory), and the Government Chemist; the Departments of Industrial Health and Social Medicine of the universities; such voluntary bodies as the Central Council for Health Education and the Industrial Welfare Society; and the research and personnel departments of various large industrial concerns. Co-ordination is provided by a number of general and special committees.

There are also Advisory Panels of experts set up by the Minister of Labour to advise him on special problems.

V

Health Services In Scotland

The health services in Scotland had the same origin and their development has followed much the same course as the health services in England and Wales. In both countries the services have evolved during the past hundred years from measures for the prevention of the outbreak and spread of pestilence into measures for community welfare and for the care of the individual, irrespective of whether he is a danger to the community or not.

PUBLIC HEALTH SERVICES

The development of the Public Health Services in Scotland has been largely on the same lines as in England, although these services have been based on separate acts, and different authorities are responsible for the various services. In Scotland the basis is the Public Health (Scotland) Act 1897 and the Burgh Police (Scotland) Act 1892.

The local authorities concerned in Scotland are the councils of counties and burghs. The county councils and large burghs (i.e. burghs with a population of twenty thousand or more) have since 1930 been the public health local authorities for all the major public health services. The county councils are also responsible for these services in the small burghs, but certain functions may be delegated to the burghs. The small burghs are responsible for local sanitary services, housing, etc.

Powers similar to those conferred on the Minister of Health by the Water Act 1945 are conferred on the Secretary of State for Scotland by the Water (Scotland) Act 1946. The local authorities concerned in Scotland with water supply (Local Water Authorities) are county councils, the town councils of all burghs and joint water boards, i.e. combinations of local authorities. The local authorities for sewerage purposes are the county councils and the town councils of all burghs.

Local authorities in Scotland have responsibilities for housing similar to those of the English authorities. Their powers are derived from the Housing (Scotland) Act 1950.

In Scotland port health control is operated by all county councils and large burghs with seaboards who are the responsible authorities. There is only one specially constituted port local authority.

Both the Secretary of State for Scotland and the Minister of Food are concerned in the central administration of the legislation relating to foods. These Ministers acting jointly can make regulations to secure the hygienic handling of foodstuffs, but the supervision of the work of Scottish local authorities in matters of food hygiene is undertaken by the Secretary of State

through the Department of Health for Scotland. The labelling and composition of foods, however, are the concern, primarily, of the Ministry of Food.

THE NATIONAL HEALTH SERVICE

The National Health Service (Scotland) Act, which received Royal Assent on 21st May 1947, and came into force on 5th July 1948, is very closely akin to the corresponding Act for England and Wales, although there are some administrative differences due to the somewhat different background against which the service must operate.

Central responsibility for the National Health Service as a whole rests with the Secretary of State for Scotland, who is assisted by the Scottish Health Services Council with members drawn from all relevant fields of experience. Standing Committees of that council have been set up in connection with particular parts of the service; these include the additional members necessary to cover particular subdivisions of the expert field.

Hospital and Specialist Services

Responsibility for the hospital and allied services also rests with the Secretary of State, to whom all existing hospitals were transferred on 5th July 1948. Regional Boards, as agents of the Secretary of State, undertake the general administration of the hospital service in their areas; and Boards of Management in turn, as agents of the Regional Boards, control and manage particular hospitals. In Scotland, teaching hospitals are included in the regional ambit and do not, as in England and Wales, have their own separate Boards of Governors responsible to the central authority alone. A Regional Board, in drawing up its scheme for the constitution of Boards of Management, was required to consult the university concerned so that the teaching hospitals might be agreed upon, and university nominees are included in the membership of the Boards of Management of these hospitals. There is also a Medical Education Committee in each region, consisting of nominees of the university, the Regional Board and the Secretary of State, to advise the Regional Board on the need for facilities for clinical teaching.

The endowments of voluntary hospitals, instead of being pooled and re-allocated by the Minister as in England, were left with the original hospitals pending re-allocation by a Hospital Endowments Commission. A proportion of these endowments have been allotted to a Scottish Hospital Endowments Research Trust set up to assist medical research in Scotland.

The Scottish National Blood Transfusion Association organizes the blood transfusion service on behalf of the Secretary of State.

General Practitioner Services

The General Practitioner Services are administered, as in England and Wales, by Executive Councils, five-sixths of whose members have been nominated locally by the authorities and professions in the locality. The same safeguards as to freedom of choice exist, and there are the same regulations governing the sale of practices and controlling the entry of doctors into practice in areas already well served in this respect.

Local Authority Services

Responsibility for the local services, e.g. maternity and child welfare services, home nursing service, preventive and after-care services, domestic help service, etc., rests with the major local authorities, that is with the county councils and the town councils of large burghs.

Ambulance Service

The duty of providing ambulances, which falls upon the Local Health Authorities in England and Wales, is undertaken in Scotland by the Secretary of State, working through the Scottish Ambulance Service (the St. Andrew's Ambulance Association and the Scottish Branch of the British Red Cross Society).

Health Centres

Health centres will come immediately under the control of the Secretary of State, and not of the local authorities as in England and Wales, for Scotland is more easily managed as a unit and conditions vary widely in different areas. The first health centre to be built in Scotland was opened in May 1953 in a suburb of Edinburgh.

Mental Care

The arrangements for mental care and treatment in Scotland are very similar to those in England and Wales. The main differences are:

1. The Secretary of State, and not the Local Health Authority, is responsible for the conveyance of mental patients to hospital.
2. The boarding-out system, which has always been a notable feature of the mental health service in Scotland, provides the advantages of family care and useful occupation both for the mentally ill and for mental defectives.
3. In addition to the usual medical and lay visitation, these boarded-out patients, and also those absent on probation or licence from mental hospitals and mental deficiency institutions, are visited regularly by the Deputy Commissioners and by the Inspector of the General Board of Control.

At the end of 1953 there were in Scotland 25,000 hospital beds for the mentally ill and mentally defective, compared with 37,263 for all other types of illness. The total number of patients with mental disorder being cared for under the National Health Service was 21,097, of whom 20,681 were in mental hospitals and 416 were boarded-out in private dwellings.

About 65 per cent of admissions to mental hospitals are now of voluntary patients (in some hospitals the proportion is over 90 per cent). At the end of 1953, 19 per cent of all patients in mental hospitals were voluntary patients.

There were 7,635 mental defectives in 1953, of whom 5,105 were in mental deficiency institutions and 2,530 were boarded-out in private dwellings.

THE SCHOOL HEALTH SERVICE

The School Health Service in Scotland operates under the provisions of the Education (Scotland) Act 1946. The Act imposes upon each Education Authority the duty of providing for the medical inspection, supervision and treatment (including the supply of appliances) of all pupils in attendance at schools and junior colleges under the Authority's management and of all pupils under 18 in attendance at other State educational establishments. It also (1) empowers each Authority to provide for the medical inspection, etc., of all pupils over 18 at other educational establishments; (2) authorizes arrangements, by agreement with the managers, for the inspection of pupils at privately run schools and colleges; and (3) gives each Authority the necessary powers to ensure the cleanliness of the bodies and clothing of pupils attending schools and other educational establishments under its management.

VI

Health Services In Northern Ireland

In general, the Health Services Act for Northern Ireland, which received the Royal Assent on 4th February 1948, follows the lines of the corresponding act in England and Wales. The benefits and services provided in Northern Ireland are similar to those provided in England and Wales—such differences as exist are mainly in administration, their effect being to minimize centralization and Government direction in Northern Ireland. The services began to operate on 5th July 1948, the same day as the National Health Service. The services in Northern Ireland are financed as in the rest of the United Kingdom.

The Minister of Health and Local Government does not administer any of the services directly. This responsibility rests with three main agencies, each of which exercises wide powers:

The Northern Ireland Hospitals Authority;

The Northern Ireland General Health Services Board; and

Local Health Authorities, which are the councils of counties and county boroughs.

The Minister is given power to set up Health Advisory Committees from time to time.

PUBLIC HEALTH SERVICES

The central authority in Northern Ireland responsible for the administration of the law relating to public health is the Ministry of Health and Local Government. Local administration is with the Local Sanitary Authorities, i.e. urban and rural district councils, and in regard to certain matters, county and county borough Health Authorities.

The Public Health and Local Government (Administrative Provisions) Act (Northern Ireland) 1946 enables various health functions carried out by Local Sanitary Authorities within the county to be placed on a county basis and transferred to the Health Authority. A number of such transfers have been made, and the result is that the Local Sanitary Authorities, while left much as they were in regard to communal hygiene, have been relieved of the administration of the personal health services which are now entrusted to County Health Authorities.

In addition to the provision of these health services, Health Authorities have also been made responsible for the enforcement of the Sale of Food and Drugs Acts, and for the notification and prevention of infectious diseases under the Infectious Diseases (Notification) Act 1889 and the Infectious Diseases (Prevention) Act 1890.

Medical and sanitary staff for the discharge of these public health functions are appointed by the Health Authority. There is a Medical Officer of Health for each county and county borough, as well as a County Sanitary Officer, and in the case of county boroughs an Executive Sanitary Officer. In a County Health Authority there are also Divisional Medical and Sanitary Officers, and these appointments are made in consultation with the Local Sanitary Authority in whose area the officer is to undertake duties. The officer is responsible to the Local Sanitary Authority for the discharge of the duties remaining with that authority, and to the County Health Authority for the discharge of the public health duties now entrusted to it.

HOSPITAL AND SPECIALIST SERVICES

Responsibility for planning and administering the hospital service is placed upon the Northern Ireland Hospitals Authority. Hospital property is transferred to the Hospitals Authority.

The functions of the Hospitals Authority are wide. The Authority undertakes the building of new hospitals; the provision of a consultant and specialist service, and of facilities for medical education and research in consultation with the Queen's University; the organization of an ambulance service (to include suitable transport for expectant or nursing mothers), a bacteriological service, a pathological service and a blood-transfusion service, not only for hospitals but for health services generally.

The management of hospitals is placed in the hands of local management committees, appointed by the Hospitals Authority after consultations with previously existing hospital authorities, hospital medical staffs, local Health Authorities, etc. Every hospital will keep its endowments, and special endowments will continue to be used for the purposes for which they were intended.

The Northern Ireland Act provides for the preservation and continuance of the tradition of each hospital. It was made the duty of the Authority to consult with management committees and to draw up a management scheme for each hospital or group of hospitals, setting out the manner in which the hospital concerned would function and the part it would play in the hospital and specialist service as a whole. Hospital Management Committees are to act within the schemes as approved; they are corporate bodies and will carry on the tradition of the hospital, having regard to its character and associations.

Mental Health Services

Mental treatment is the responsibility of the Hospitals Authority, which has several members with experience in the administration of mental health services. A Standing Committee of the Hospitals Authority exercises in a responsible executive capacity certain functions of the Authority relating to mental services, but not the raising of loans, the taking of land, or the general control of expenditure. A majority of the members of the Standing Committee are persons either with experience in the administration of mental health services or with suitable professional qualifications.

Eye Services

Under the Health Services Act it is a function of the Hospitals Authority to make, in accordance with Regulations, arrangements with doctors and ophthalmic and dispensing opticians for the testing of sight and the supply of optical appliances, and these facilities at present exist and are provided through the medium of the Supplementary Eye Services. Provision is also made in the statute enabling the Minister of Health and Local Government, if he is satisfied that adequate Eye Services are available in any area through hospital and specialist services, to direct that Supplementary Eye Services in that area should cease.

The administration of Eye Services is in the care of a Standing Committee of the Hospitals Authority on which ophthalmologists and opticians serve as members.

GENERAL HEALTH SERVICES

There is one important difference in the conditions of service of the doctor in Northern Ireland as compared with his colleague in Great Britain. The Northern Ireland practitioner has the right to appeal to the Supreme Court in the case of disqualification from the Service, not to the Minister of Health as in England and Wales.

In addition to making arrangements for general practitioner, general dental and pharmaceutical services, the General Health Services Board has certain other duties, for example, the responsibility for providing health centres where these are considered necessary. The Board may also supplement and reinforce the work of the individual practitioners by educating the public in the essentials of good health and by arranging courses of study for the doctors, dentists and chemists taking part in the scheme. It also falls to the Board to control the rate of admission of new doctors to participate in general medical services.

HEALTH AUTHORITY SERVICES

The role of the County and County Borough Health Authorities is an extension and development of that created for them by the Public Health and Local Government (Administrative Provisions) Act (Northern Ireland) 1946. Certain functions which were permissive under the Act of 1946 are now obligatory: these include the provision of a Maternity and Child Welfare Service. The greatest change, however, is that all the services provided by local authorities under the Health Services Act (chiefly domiciliary and clinic services) form part of a comprehensive service for everyone. A person is as fully entitled to ask for advice and assistance at a maternity and child welfare clinic in any part of Northern Ireland as for medical attention from a doctor or treatment at any hospital.

In order to co-ordinate local authority services with the other health services, Health Authorities were required to consult with the other statutory bodies in drawing up their schemes.

TUBERCULOSIS SERVICE

On 1st September 1947 the Northern Ireland Tuberculosis Authority became responsible for the Tuberculosis Service in accordance with the provisions of the Public Health (Tuberculosis) Act (Northern Ireland) 1946. This Act was designed to enable the Authority to take all measures for the prevention and treatment of the disease, and since the services were brought under the operation of one central authority considerable progress has been made.

SCHOOL HEALTH SERVICE

In Northern Ireland the School Health Service is administered by the County and County Borough Health Authorities to whom it was transferred from Local Education Authorities on 1st April 1948. One of the principal objects of this arrangement is to secure the fullest integration of the School Health and Child Welfare Services. In day-to-day administration of the School Health Service, however, there is no substantial difference from the arrangements in operation in Great Britain. Local Education Authorities are responsible for the School Meals Service, and milk is supplied free for the pupils of all schools through the agency of the Ministry of Agriculture.

INDUSTRIAL HEALTH

The health and welfare of industrial workers in Northern Ireland are safeguarded by arrangements similar to those obtaining in Great Britain, with comparable legislation and inspectorates. The Departments responsible are the Ministry of Labour and National Insurance, for factory welfare, and the Ministry of Commerce, for welfare in mines and quarries.

VII

Medical Research

Medical research in universities, hospitals, clinics, institutions, etc., has for many years been recognized by the British Government as of paramount importance in maintaining and improving the standards of medical services. Chief of all organizations engaged in this work is the Medical Research Council, which is under the statutory authority of a Committee of the Privy Council. Under the National Health Service Act 1946 (Section 16), the Minister of Health (in England and Wales) was made responsible for instituting and maintaining research work, without altering the functions of the Medical Research Council. The Health Departments of the United Kingdom already did a certain amount of research work (usually of an *ad hoc* type) by agreement with the Council, and the purpose of this clause in the 1946 Act was simply to broaden the basis upon which the work is done. Similar powers were given to the Secretary of State for Scotland under the corresponding Scottish Act.

In the financial year 1954–55 the sum specifically allocated from taxes for medical research in Great Britain totals £2,031,100, and comprises £1,947,109 for the work of the Medical Research Council and £84,000 to be expended by the Health Departments on special inquiries into diseases and other research services. These sums do not include the cost of the considerable amount of research carried out in the ordinary hospital services and in the bacteriological services. The Public Health Laboratory Service administered by the Medical Research Council for the Ministry of Health covers 'pure' and 'applied' pathological research in connection with infectious diseases, and under its auspices epidemiological studies are carried out in the field.

An important contribution to research in particular branches of medicine is made by private charities of which the British Empire Cancer Campaign and the Nuffield Foundation are the largest. There is close co-operation between the Medical Research Council and other organizations supporting medical research; this ensures the best allocation of their respective resources.

THE MEDICAL RESEARCH COUNCIL

The Medical Research Council has the duty within the United Kingdom, and on occasion elsewhere, of promoting medical research of all kinds, including research which requires direct access to patients and the use of such clinical facilities as have, by virtue of the National Health Service Acts, come under the jurisdiction of the Minister of Health and the Secretary of State for Scotland.

The Medical Research Council is composed of twelve members, who are appointed by the Privy Council Committee and who retire in rotation at

regular intervals. Of these twelve, nine are appointed for their scientific qualifications in the different branches of curative and preventive medicine after consultation with the President of the Royal Society and the Medical Research Council itself, while three—at least one of whom must be a member of the House of Lords and another a member of the House of Commons—are appointed for general rather than for scientific qualifications.

The Council, by its constitution, has full liberty to pursue an independent scientific policy, to control all its own work and to appoint its own research officers. It is financed by a grant-in-aid which is the subject of a Vote in the Civil Estimates[1], and by funds accruing to it through grants or gifts from public bodies or private benefactors.

There are three main methods by which the Medical Research Council supports and subsidizes medical research:

1. By employing a scientific and technical staff of its own. This numbers about 1,000, of whom some 150 are medically and 300 scientifically qualified.
2. By making temporary grants for research projects directly to independent workers in universities, hospitals and elsewhere. Generally, grants are made directly to individuals and not to institutions.
3. By awarding studentships and fellowships to enable promising young graduates to be trained, under suitable direction, in the methods of medical research.

The fundamental research activities of the Council (including research into special subjects) are conducted in the National Institute for Medical Research at Mill Hill, London (which is equipped with all the most up-to-date scientific devices), and its associated laboratories, and in some fifty smaller establishments (generally known as Research Units or Groups) usually attached to external institutions.

The programme of research work undertaken by the Council is planned in accordance with both need and opportunity, and individual items are therefore constantly changing. In general, however, the programme includes:

1. fundamental studies of the structure and natural processes of the body and of other organisms which may be associated with it, to provide a basis for the better understanding of problems of health and disease, e.g. studies in physiology, biochemistry, biophysics, nutrition, genetics, etc.;
2. clinical and laboratory studies of disease; its nature and causes, and methods for its prevention, diagnosis and treatment, e.g. studies in cardiovascular disorders, sensory disorders, mental disorders, alimentary disorders, dental disorders, skin disorders, pediatrics, malignant diseases, epidemics, tuberculosis, tropical diseases, wound infections, etc.;

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[1] Vote 6 (Medical Research Council) in Class V (Health, Housing, and Local Government).

3. the development and evaluation of special methods of treatment and also of prophylaxis and diagnosis, e.g. studies in chemotherapy, radiotherapy, immunology and bacteriology, blood transfusion, anæsthesia, electrical methods for the diagnosis of disease, pharmacology, etc.; and
4. the study of social and occupational factors affecting health and the efficiency of body and mind, e.g. studies in social medicine, environmental and occupational physiology, occupational psychology, occupational diseases, etc.

In planning and carrying out its research programme, the Council may be assisted by technical committees, which it is empowered to appoint to advise on special subjects. An important new advisory committee to the Council is the Clinical Research Board, set up in consultation with the Health Departments to assist the development of clinical research in the National Health Service.

The results of the great majority of investigations supported by the Council are reported by the workers concerned in papers contributed on their own initiative to medical and other scientific journals. In addition the Council publishes a series of *Special Reports*, and a series of *Memoranda*, apart from its Annual Report to Parliament.

The Public Health Laboratory Service

The Public Health Laboratory Service in England and Wales began as an emergency service in the second world war. It became part of the permanent machinery for dealing with infectious diseases by the National Health Service Act 1946.

The Service provides a network of bacteriological laboratories throughout England and Wales to assist in the diagnosis, prevention and control of epidemic diseases, the largest establishment being the Central Public Health Laboratory at Colindale, in North-West London, which includes the National Collection of Type Cultures, the Standards Laboratory for the Supply of Diagnostic Cultures and Sera, and reference libraries specializing in the identification of infective micro-organisms. In addition to Colindale, there are six regional laboratories at university centres, and 46 area laboratories.

VIII

Professional Training

Only persons whose names are on the medical register can practise as doctors in the National Health Service, and only persons whose names are on the dental register can practise dentistry in Britain. The minimum qualification for registration requires, for a doctor, five to seven years' training in medical school and hospital, and, for a dentist, four years at a dental school.

MEDICINE

The medical profession is regulated by the Medical Act 1858, and the Medical Act 1950. The former set up the General Medical Council, the governing body of the profession, and prohibited practice by unqualified persons. The latter reconstituted the General Medical Council and set up a medical disciplinary committee of Council members. It also requires that before becoming fully registered and entitled to set up in private practice a medical student must spend at least a year after the completion of his examinations in satisfactory service in a resident medical capacity in one or more approved hospitals or institutions.

The General Medical Council now consists of 45 members, including eight members nominated by the Crown (of whom five are registered medical practitioners, and three laymen), eight elected members (six from England and Wales and two from Scotland), and members chosen by the universities and colleges.

There are 16 universities granting degrees in medicine and surgery. In addition, the Royal College of Physicians and the Royal College of Surgeons (in England and in Scotland), and the Apothecaries Society of London grant diplomas which are recognized by the General Medical Council. Higher qualifications obtainable after the original degree or diploma are: university degrees of Doctor of Medicine (MD) and Master of Surgery (MS); Membership or Fellowship of one of the Royal Colleges of Physicians (MRCP; FRCP); Fellowship of one of the Royal Colleges of Surgeons (FRCS).

There are in all about 140 hospitals in Great Britain with medical teaching facilities. The 26 London teaching hospitals are in fact groups of hospitals, and include over 60 individual hospitals, while the 10 teaching hospitals in Wales or provincial centres cover over 40 institutions.

Each of the twelve autonomous undergraduate medical schools of London is linked with one of the teaching hospitals—St. Bartholomew's ('Bart's'), St. Thomas's, St. Mary's, St. George's, the London, the Middlesex, the Westminster, the Royal Free, University College, King's College, Guy's, or Charing Cross. These hospitals are used for postgraduate as well as undergraduate training, but the other 14 London teaching hospitals are reserved for postgraduate study.

The British Postgraduate Medical Federation is a School of the University of London, and comprises the Postgraduate Medical School at Hammersmith Hospital and institutes in the various clinical branches of medicine and surgery associated with the special postgraduate teaching hospitals.

The 10 Welsh and provincial teaching hospitals are the United Hospitals of Cardiff, Newcastle (associated with Durham University), Leeds, Sheffield, Cambridge, Oxford, Bristol, Birmingham, Manchester and Liverpool.

DENTISTRY

The dental profession is governed by the Dentists Act 1921.

There are 14 universities granting degrees in Dental Surgery (BDS) and diplomas as Licentiate of Dental Surgery (LDS). Over and above these, diplomas are granted by the Royal College of Surgeons of England, the Royal College of Surgeons in Ireland, the Royal College of Surgeons of Edinburgh, and the Royal Faculty of Physicians and Surgeons of Glasgow.

Higher qualifications obtainable after initial qualification are: Master of Dental Surgery (MDS); Master of Surgery (Dental Surgery) (MS (Dent.)); Doctor of Dental Surgery (DDS); Fellow in Dental Surgery (FDS); Higher Dental Diploma (HDD).

The Dental Board of the United Kingdom consists of thirteen members: a chairman and three laymen nominated by the Crown, three medical practitioners appointed by the General Medical Council, six elected members (two for England and Wales, one for Scotland, one for Ireland, and two representing dentists registered under the Dentists Act 1921).

OTHER PROFESSIONS

The minimum period of hospital training required to qualify for registration as a nurse is three years. The theoretical work required for the examinations is done either at the same time as the practical nursing, or, in some hospitals, in intermittent periods of full-time study. The registered nurse trained in general nursing is entitled to use the letters SRN (State Registered Nurse) after her name, or, in Scotland, RGN (Registered General Nurse).

The minimum period of training required to qualify for certification as a midwife (SCM) is one year for registered nurses trained in general or sick children's nursing (who now constitute 94 per cent of all pupils) and two years for others. Training takes place partly in hospital and partly in the patients' own homes.

Pharmacy is regulated by the Pharmacy Acts 1852 to 1953. Only registered pharmacists may describe themselves, or practise, as pharmacists, and qualifications requiring four to six years' vocational training are necessary for registration. Medicines may only be dispensed under the supervision of a pharmacist. The governing body of the profession, responsible for keeping the register, is the Pharmaceutical Society of Great Britain.

Other medical auxiliaries are radiographers, physiotherapists, occupational therapists, speech therapists, almoners, dietitians, laboratory technicians, and

chiropodists. At least two to three years' professional training is required, in addition to a good general education, to obtain the qualifications for these professions recognized for registration on the Auxiliary Medical Register or with the appropriate professional body. While registration is not legally essential to the following of these callings, it is usually in practice necessary for progress in, or even entry to, them.

APPENDIX I

COST OF THE NATIONAL HEALTH SERVICE

(including Civil Defence)

1st April 1952–31st March 1953

£ million

	England [1] and Wales	Scotland [1]	Northern Ireland	United [1] Kingdom
Gross Expenditure:				
TOTAL	459·0	54·9	12·9	526·8
Hospital, Specialist and Ancillary Services	270·7	32·9	7·3	310·9
General Medical Services	77·6 [3]	9·3	2·4	89·3
Pharmaceutical Services	35·7	5·3	1·6	42·5
General Dental Services	18·0	2·5	0·6	21·0
Supplementary Ophthalmic Services	5·8	0·6	0·2	6·5
Compensation for loss of right to sell medical practices	5·4	0·4	0·1	5·9
Grants to Local Health Authorities [2]	19·4	1·8	0·3	21·5
Central purchase of medical supplies, stores and equipment	4·8	0·2	—	4·9
Superannuation	4·3	0·5	0·1	4·9
Civil Defence (medical services) ..	9·0	0·4	—	9·4
Miscellaneous	8·4	1·0	0·3	9·8
Receipts:				
TOTAL	69·1	7·4	1·8	78·4
National Insurance Fund contributions [4]	36·8	4·1	0·9	41·8
Miscellaneous [5]	32·3	3·4	0·9	36·6

[1] Estimated.

[2] These grants represent 50 per cent of the cost of these services, the balance being met by local authorities from local rates.

[3] Including an award to medical practitioners, estimated at £25·4 million, for arrears of increased remuneration for the period 5th July 1948 to 31st March 1952.

[4] Representing 10*d.* per week from the total contribution for each man and 8*d.* from that for each woman in the scheme.

[5] Mainly contributions and transfer values in respect of superannuation, recoveries for hospital services and medical supplies, and receipts from the Hospital Endowments Fund towards the cost of discharging the liabilities at 5th July 1948 of transferred voluntary hospitals. The figures for England and Wales include the estimated sum of £890,000 in respect of Civil Defence.

[Source: *Annual Abstract of Statistics.*]

APPENDIX II

READING LIST

Government Publications

(obtainable from H.M. Stationery Office, London, and its agents, unless otherwise stated)

Statutes

Dentists Act 1921. 6d.
Factories Act 1937. 4s.
Factories Act 1948. 6d.
Factories Act (Northern Ireland) 1938. *HMSO, Belfast.*
Factories Act (Northern Ireland) 1949. *HMSO, Belfast.* 6d.
Food and Drugs Act 1938. 2s.
Food and Drugs (Milk, Dairies and Artificial Cream) Act 1950. 1s. 3d.
Health Services Act (Northern Ireland) 1948. *HMSO, Belfast.* 2s.
Health Services Act (Northern Ireland) 1953. *HMSO, Belfast.* 1s.
Health Services Acts Amendment Act (Northern Ireland) 1950. *HMSO, Belfast.* 2d.
Health Services (Administrative Provisions) Act (Northern Ireland) 1952. *HMSO, Belfast.* 4d.
Health Services (Temporary Provisions) Act (Northern Ireland) 1950. *HMSO, Belfast.* 2d.
Housing Act 1936. 3s. 6d.
Housing Act 1949. 1s. 9d.
Housing (Scotland) Act 1950. 3s.
Joint Nursing and Midwives Council Act (Northern Ireland) 1922. *HMSO, Belfast.*
Medical Act 1950. 9d.
Mental Deficiency Act 1913. 1s. 3d.
Mental Health Act (Northern Ireland) 1948. *HMSO, Belfast.* 2s. 3d.
Mental Treatment Act 1930. 1s.
Midwives Act 1951. 9d.
Midwives (Scotland) Act 1951. 9d.
National Health Service Act 1946. 3s.
National Health Service Act 1951. 4d.
National Health Service Act 1952. 4d.
National Health Service (Amendment) Act 1949. 1s. 3d.
National Health Service (Scotland) Act 1947. 1s. 6d.
Nurses Act 1943. 6d.
Nurses Act 1949. 6d.
Nurses Act (Northern Ireland) 1946. *HMSO, Belfast.* 6d.
Nurses Registration (Ireland) Act 1919.
Nurses (Scotland) Act 1949. 6d.
Nurses (Scotland) Act 1951. 1s.
Nurses Registration Act 1919. 3d.
Pharmacy Acts 1852 to 1953.
Public Health Act 1936. 6s.
Public Health and Local Government (Administrative Provisions) Act (Northern Ireland) 1946. *HMSO, Belfast.* 6d.
Public Health (Tuberculosis) Act (Northern Ireland) 1946. *HMSO, Belfast.* 6d.
River Boards Act 1948. 1s. 3d.
Rural Water Supplies and Sewerage Act 1944. 4d.
Rural Water Supplies and Sewerage Act 1951. 2d.
Water Act 1945. 3s.
Water Act 1948. 4d.

Annual Reports of the

Board of Control (Lunacy and Mental Treatment). For 1952, 1953. 6d.

Central Health Services Council. For 1952, 1953. 1s. 3d.

Chief Inspector of Factories. For 1951, Cmd. 8772. 1953. 6s. 6d.

Chief Inspector of Factories (N. Ireland). For 1952, Cmd. 316. *HMSO, Belfast.* 1953, 1s.

Chief Medical Officer of the Ministry of Education: The Health of the School Child. For 1950 and 1951. 1952. 5s.

Department of Health for Scotland and the Scottish Health Services Council. For 1953, Cmd. 9107. 1954. 4s. 6d.

Medical Research Council. For 1951–52, Cmd. 8876. 1953. 6s. 6d.

Ministry of Education. For 1952, Cmd. 8835. 1953. 5s.

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Annual Statistics, etc.

Ambulance Services Costing Return. For 1951–52. 1953. 3s.

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Housing in Britain. Reference Pamphlet RF.P. 2797. 1954 [to be issued shortly].

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Rehabilitation and Resettlement in Britain. Reference Paper R.1773. 1949 [under revision].

APPENDIX III

LIST OF HEALTH DEPARTMENTS AND ORGANIZATIONS

Government Departments and Official Bodies

Ministry of Health, Savile Row, London, W.1.
Ministry of Fuel and Power, 7, Millbank, London, S.W.1.
Department of Health for Scotland, St. Andrew's House, Edinburgh.
Ministry of Health and Local Government, Northern Ireland, Belfast.
Ministry of Labour and National Service, 8, St. James's Square, London, S.W.1.
Ministry of Labour and National Insurance, Northern Ireland, Belfast.
Ministry of Education, Curzon Street House, Curzon Street, London, W.1.
Scottish Education Department, St. Andrew's House, Edinburgh.
Ministry of Education, Northern Ireland, Netherleigh, Massey Avenue, Stormont, Belfast.
Board of Control, Savile Row, London, W.1.
General Medical Council, 44, Hallam Street, London, W.1.
General Register Office, Somerset House, Strand, London, W.C.2.
Medical Research Council, 38, Old Queen Street, London, S.W.1.

Professional Bodies

Apothecaries Society of London, Apothecaries Hall, Blackfriars Lane, London, E.C.4.
Association of Dispensing Opticians, 50, Nottingham Place, London, W.1.
Association of Industrial Medical Officers, c/o Peek Frean & Co., Keeton's Road, London, S.E.16.
Association of Mental Health Workers, c/o N.A.M.H., 39, Queen Anne Street, London, W.1.
Association of Occupational Therapists, 251, Brompton Road, London, S.W.3.
Association of Optical Practitioners, 65, Brook Street, London, W.1.
Association of Psychiatric Social Workers, 1, Park Crescent, London, W.1.
Board of Registration of Medical Auxiliaries, B.M.A. House, Tavistock Square, London, W.C.1.
British Dental Association, 13, Hill Street, London, W.1.
British Dietetic Association, 251, Brompton Road, London, S.W.3.
British Medical Association, Tavistock House, Tavistock Square, London, W.C.1.
British Optical Association, 65, Brook Street, London, W.1.
British Orthopædic Association, 45, Lincoln's Inn Fields, London, W.C.2.
British Orthoptic Society, Herne House Farm, Ruckinge, near Ashford, Kent.
British Tuberculosis Association, 16, Grosvenor Place, London, S.W.1.
Chartered Society of Physiotherapy, Tavistock House (South), Tavistock Square, London, W.C.1.
College of Speech Therapists, 68, Queen's Gardens, London, W.2.
Institute of Almoners, Tavistock House (North), Tavistock Square, London, W.C.1.
Institute of Hospital Administrators, 75, Portland Place, London, W.1.
Institute of Medical Laboratory Technology, 9, Harley Street, London, W.1.
Institute of Personnel Management, Management House, Hill Street, London, W.1.
Institute of Welfare (*Industrial*), 374, City Road, London, E.C.4.
Moral Welfare Workers' Association, Church House, Dean's Yard, London, S.W.1.
National Association of Home Help Organisers, Alhambra House, 31, Charing Cross Road, London, W.C.2.
Pharmaceutical Society of Great Britain, 17, Bloomsbury Square, London, W.C.1.
Queen's Institute of District Nursing, 57, Lower Belgrave Street, London, S.W.1.
Royal College of Midwives, 57, Lower Belgrave Street, London, S.W.1.
Royal College of Nursing, 1A, Henrietta Place, London, W.1.

Royal College of Physicians, 12, Pall Mall East, London, S.W.1.
Royal College of Physicians, 9, Queen Street, Edinburgh, 2.
Royal College of Surgeons of Edinburgh, Nicholson Street, Edinburgh, 8.
Royal College of Surgeons of England, Lincoln's Inn Fields, London, W.C.2.
Royal Institute of Public Health and Hygiene, 28, Portland Place, London, W.1.
Royal Sanitary Institute, 90, Buckingham Palace Road, London, S.W.1.
Royal Society of Medicine, 1, Wimpole Street, London, W.1.
Sanitary Inspectors' Association, 19, Grosvenor Place, London, S.W.1.
Society of Chiropodists, 21, Cavendish Square, London, W.1.
Society of Medical Officers of Health, Tavistock House (South), Tavistock Square, London, W.C.1.
Society of Radiographers, 32, Welbeck Street, London, W.1.
Women Public Health Officers' Association, 7, Victoria Street, London, S.W.1.

Other Bodies

British Council for Rehabilitation, Tavistock House (South), Tavistock Square, London, W.C.1.
British Council for the Welfare of Spastics, 26, Cranleigh Parade, Limpsfield Road, Sanderstead, Surrey.
British Epilepsy Association, 16, Gloucester Walk, London, W.8.
British Red Cross Society, 14, Grosvenor Crescent, London, S.W.1.
British Rheumatic Association, 11, Beaumont Street, London, W.1.
British Social Biology Council, Tavistock House (South), Tavistock Square, London, W.C.1.
Central Council for the Care of Cripples, 34, Eccleston Square, London, S.W.1.
Central Council for Health Education, Tavistock House, Tavistock Square, London, W.C.1.
Central Council of Physical Recreation, 6, Bedford Square, London, W.C.1.
The Diabetic Association, 152, Harley Street, London, W.1.
Industrial Welfare Society, 48, Bryanston Square, London, W.1.
Infantile Paralysis Fellowship, Rugby Chambers, Great James Street, London, W.C.1.
Invalid Children's Aid Association, 4, Palace Gate, London, W.8.
King Edward's Hospital Fund for London, 10, Old Jewry, London, E.C.2.
Mental After Care Association, 108, Jermyn Street, London, S.W.1.
Multiple Sclerosis Society, 9, Grosvenor Crescent, London, S.W.1.
National Association for Maternal and Child Welfare, 5, Tavistock Place, London, W.C.1.
National Association for Mental Health, 39, Queen Anne Street, London, W.1.
National Association for the Paralysed, Tavistock House (South), Tavistock Square, London, W.C.1.
National Association for the Prevention of Tuberculosis, Tavistock House (North), Tavistock Square, London, W.C.1.
National Association of Parents of Backward Children, 84/86, Chancery Lane, London, W.C.2.
National Council for the Unmarried Mother and Her Child, 21, Coram Street, London, W.C.1.
National Institute for the Deaf, 105, Gower Street, London, W.C.1.
National Institute of Industrial Psychology, 14, Welbeck Street, London, W.1.
National Society for Epileptics, Chalfont Colony, Chalfont St. Peter, Bucks.
National Society of Children's Nurseries, 45, Russell Square, London, W.C.1.
National Spastics Society, 44, Stratford Road, London, W.8.
Nuffield Provincial Hospitals Trust, Nuffield Lodge, Regent's Park, London, N.W.1.
Order of St. John, St. John's Gate, London, E.C.1.
Royal National Institute for the Blind, 224, Great Portland Street, London, W.1.
Royal Society for the Prevention of Accidents, 52, Grosvenor Gardens, London, S.W.1.
Saint Andrew's Ambulance Association, 17, Great Stuart Street, Edinburgh, 3.
St. Dunstan's (*for war-blinded*), 191, Marylebone Road, London, W.1.
Scottish Association for the Deaf, 36, Roseangle, Dundee.

Scottish Association for Mental Health, 57, Melville Street, Edinburgh, 3.
Scottish Council for the Care of Spastics, Westerlea, Ellersley Road, Edinburgh, 12.
Scottish Council for Health Education, 3, Castle Street, Edinburgh.
Scottish Council for the Unmarried Mother and Her Child, 11, St. Colme Street, Edinburgh, 3.
Scottish National Federation for the Welfare of the Blind, 4, Coates Crescent, Edinburgh, 3.
Scottish National Institution for the War Blinded, Gillespie Crescent, Edinburgh, 10.
Shaftesbury Society (*cripple care*), 32, John Street, London, W.C.1.

INDEX

(8827) 433603 Wt. 46776/P1439 3,840 7/54 W.P. Ltd. Gp. 587

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